CITY OF MESA
FLEXIBLE BENEFITS PLAN ENROLLMENT FORM
PLAN YEAR _____

EMPLOYEE NAME:_____ EMP #:_____
DEPARTMENT:_____ RC #:_____
EMPLOYEE ADDRESS:_____
_____

EMPLOYEE SSN: _____-_____-_____

I elect to enroll in the:

☐ Medical Reimbursement account for $_____ per plan year (plan limit is $3,000 per year). Medical expenses for employee and eligible dependents.

☐ Dependent Care Reimbursement account for $_____ per plan year (plan limit is $5,000 per year). Child care/Day care expenses for eligible dependents (this is **NOT** for medical expenses for dependents).

I certify that I have read and understand the provisions of this program and that a Summary Plan Description has been given to me.

I hereby authorize the City of Mesa to payroll-deduct the amount designated per account above.

THE EMPLOYEE UNDERSTANDS THAT REDUCED AMOUNTS OF TAXABLE COMPENSATION NOT USED FOR BENEFITS UNDER THIS PLAN ARE "FORFEITED". THE EMPLOYEE FURTHER UNDERSTANDS THAT, ONCE AMOUNTS HAVE BEEN ASSIGNED TO AN ACCOUNT, THEY CANNOT BE TRANSFERRED TO THE OTHER ACCOUNT.

Further, the employee accepts responsibility for the proper treatment of benefits paid under this plan with respect to all individual income tax reporting.

This election is irrevocable during the effective period.

Employee Signature_____ Date_____